Appendix D – Public Comment Aggregated Themes and DMAS Summary Responses

The development of this 1115 waiver application has been an evolution, engaging stakeholders at each point of the process. DMAS recognizes that the unified waiver approach, merging MLTSS and DSRIP together, is significant; however, the opportunity is greater. To that end, each component of the application was given unique attention, resulting in 3 key public comment opportunities, all meeting the CMS requirements. The final public comment exercise merged the previous efforts and included many suggestions and elements of feedback, as acknowledged by many stakeholders in the third public comment solicitation responses. As reflected in the requested documentation, DMAS extended public comment requests in writing, in person, and via teleconference and WebEx. In addition to these formal public comment solicitations, there have been significant efforts to engage stakeholders in meetings and brain storming sessions, all in attempt to ensure the Departments efforts are strategic, comprehensive, and innovative. DMAS fully intends to maintain engagement of stakeholders both at large, and in targeted groups as the Department further refines and develops program specifics. DMAS will also look to form an advisory coalition to ensure ongoing engagement over the course of the 5 year demonstration.

1. MLTSS:
    - General Approach Proposal: May 18 – June 16, 2015 Public Comment Document
    - Model of Care: September 1 – September 30, 2015 Public Comment Document
2. DSRIP:
    - Concept Paper: September 11 – October 19, 2015 Public Comment Document
3. Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority):
    - Waiver: December 4, 2015 – January 6, 2016 Public Comment Document

Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority):

Public Comment Themes and Departmental Response

Period 12/04/15—1/06/16

The comments are organized to reflect themes that surfaced across the range of public comments received, with headers indicating the represented perspective.

Note: no comments were received regarding the administrative transition of the §1915(c) waivers to the §1115 authority.

Stakeholder Group	Comment Theme	DMAS Response
Overall Approach		
Advocates	The combination of the Medicaid Managed Long-Term Services and Supports (MLTSS) initiative with the Delivery System Reform Incentive Payment (DSRIP) Program is ingenious and creates exciting synergies to transform Virginia's Medicaid program.	DMAS appreciates the recognition that the combination of these two initiatives allows Virginia to further transform the Virginia Medicaid program.
Health Plans	Expression that it is positive to see the focus on beneficiaries with high utilization as a key objective of the proposed DSRIP Program and is embedded in the approach in MLTSS as well. Acknowledgment that the MLTSS hypothesis includes reducing service gaps and providing coordination between physical and behavioral health, and LTSS is a key opportunity. Acknowledgment that DSRIP and MLTSS have the opportunity to be leveraged together to both improve care in the short-term and to make systematic improvements in the longer term, thereby helping lock in the gains of both quality of care and cost effectiveness.	DMAS appreciates the acknowledgement that leveraged together, DSRIP and MLTSS offers a significant opportunity to strengthen and improve the Medicaid delivery system, resulting in better health and experience for Medicaid beneficiaries, and better supported providers, facilitating stronger relationships between members, providers, community partners, the state, and MCOs.
	Affirmation that as currently proposed, the waiver design represents a shift in the right direction towards improved communication, accountability, and value.	DMAS appreciates the recognition of a thoughtful approach and proposal.
Providers	…the waiver program is designed to, "enable providers,	DMAS agrees that aligning DSRIP and MLTSS is a

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	community support services, and Medicaid managed care plans (MCOs) the opportunity to better coordinate and integrate member care. Taken together, alignment of the programs and providing care coordination opportunities among providers, community support services and MCOs promotes a strong infrastructure likely to strengthen and integrate Virginia's Medicaid community delivery structure and accelerate value-based payment structures.	significant opportunity to strength the Medicaid delivery structure and accelerate value-based payment methods. DMAS looks forwarding to working together to identify opportunities to infuse stronger relationships with community partners as part of the VIP structure in providing care to Medicaid beneficiaries.
	Pleased to see the references to workforce development especially for working with individuals with behavioral health needs and developmental and physical/sensory disabilities and the variety of clinical improvement projects (C1-10) many of which address critical needs in the ID/D community.	DMAS recognizes the significant opportunity enabled through DSRIP to focus on workforce development, particularly as it pertains to strengthening community based options for individuals with disabilities. DMAS intends to work with community based providers and stakeholders to further develop this training framework and model.
Concerns Regarding Overall Approach		
Advocates	Concerns expressed regarding the waiver amount, duration, and scope	This waiver strategy is common in allowing states to 'waive' the requirement that all Medicaid services must be provided in the same amount duration and scope. This is the authority granted that allows for different waiver populations to receive the targeted services needed, while not requiring the state to make them available for the general Medicaid population.
Health Plans	Suggests applying DSRIP to the MLTSS program is premature.	DMAS understands the nuances and complexities of providing care and coverage to the MLTSS populations; however, coordinating the DSRIP and MLTSS opportunities allows for providers to be

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		supported in a way that traditional Medicaid funds cannot support them. DMAS is confident in this approach and anticipates that supporting providers to be able to move towards a value-based payment model will ultimately render a more financially sustainable Medicaid program.
MLTSS Specific Comments		
Advocates	Ensure that changes are person-centered and family-centered and allow individuals to live as independently as possible and to exercise control over their own care arrangements. Encourage the State to require MCO contracts to have more involvement and training regarding relationships with family caregivers Enrollment into Managed Care needs to ensure continuity with current providers DMAS should employ a robust MCO readiness criteria for participating plans and then take a hands on management approach in overseeing the managed care contracts Reinvestment of savings should be a priority. The key investment would be back into community-based settings	The Department appreciates this perspective and has included language to emphasize the importance of family caregivers in the care planning of individuals enrolled in the program. Additionally, DMAS values the relationships with MCOs and will look to selected plans to be accountable for creating strong provider networks and relationships with beneficiaries. Additional standards of accountability and transparency will be incorporated into the MCO/DMAS contractual agreement.
Health Plans	Encourages use of any auto-assignment preference based on D-SNP affiliation with the full operationalization of the D-SNP provision	This policy decision has not been finalized and program staff will be considering all options prior to making the decision regarding auto-assignment.
	Requests MCOs owned by health systems do not receive preferential treatment in rates or membership by contracting with their own health plan	This policy decision has not been finalized and program staff will be considering all options prior to setting the final policy.
	Supports the provision of a fully integrated benefit	DMAS appreciates the support and acknowledges

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	through the MLTSS program.	that fully integrated care is the best care model for Medicaid beneficiaries.
	Supports the proposed requirement of MCOs to be certified as D-SNP plans in the same locality	DMAS understands that there is significant benefit in providing the continuity of coverage between Medicaid and Medicare. This proposed requirement is intended to support this understanding.
	Requests consideration of enrollment process which auto-assigns dual eligible members with Medicaid MCOs already providing members with medical benefits through a MA program in instances where the MA plan also participates in the MLTSS program.	DMAS has not set this policy decision though agrees that continuity between Medicare and Medicaid is valuable.
	Recommends the use of standardized quality metrics applicable to the LTSS population	DMAS agrees that standardization is critical in being able to support multiple plans and provider types who capture and report multiple data elements to multiple systems. DMAS will work with all parties to identify the best existing tools and other needed measures for quality reporting purposes.
	We do not feel that the Department's experience with the CCC program justifies the need to create an additional administrative layer for managing 'high-risk' members. If the goal is to bring greater budget predictability and highest-quality care to our most complex and vulnerable members by including them into Managed Care arrangements, we do not believe the current 1115 draft waiver has laid out the most effective way of meeting these goals.	DMAS believes the opportunity provided through the §1115 innovation waiver allows the Department to test new models of care delivery for Virginia's high-risk Medicaid beneficiaries. DMAS values managed care and will use the opportunity provided through a §1115 waiver to modify 'business as usual' with the goal of creating a more efficient, high-touch, care delivery model for its Medicaid members.
Providers	Concern regarding increased audits and other administrative processes as a result of MLTSS and the potential inclusion of more than 3 MLTSS health plans.	DMAS respects this concern and is considering how best to maintain accountability among providers and plans, while acknowledging the cumbersome nature of audits and reporting. DMAS intends to consider the needs and resource capacity of partners when

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		determining the policy for these business practices.
	Suggest planning an abundance of provider training early in 2016 with the MCOs and DMAS as was completed with the CCC rollout. Establish provider advisory groups early in 2016 to get input on how to have a successful MLTSS rollout	DMAS agrees that having provider trainings with all parties is necessary in order to ensure a successful rollout of the MLTSS demonstration. DMAS intends on engaging partners early and often.
	Concern expressed regarding the exclusion of the IDD waiver population	The application explains, "individuals enrolled in the Intellectual Disability, Developmental Disability, and Day Support waivers will continue to receive their HCBS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these waivers. Individuals residing in ICF-ID facilities will be excluded from MLTSS until after the completion of the redesign."
	Suggestion that DMAS require any MLTSS MCO to undergo claims testing with providers prior to the system "go live"	DMAS appreciates this suggestion and will take strong consideration in encouraging a testing environment for future program development.
	The case management process under the CCC program was not effective in providing services to individuals in the long-term care setting. The MLTSS program needs to clearly define the role of the case managers. While case management may benefit individuals in the community setting to identify and obtain services, case management is not needed during the time the person is in a long-term	DMAS appreciates the spirit of this comment and agrees that roles need to be clearly defined between providers, including long-term care facility providers, and health plans. DMAS will work with all partners to consider roles and responsibilities so that Medicaid beneficiaries can be best supported no matter the setting they choose to receive care.

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	care facility.	
	Where opportunities exist to mandate uniformity of processes between insurance carriers this should be included in the contracts between the state and insurance carriers to maximize the success of the program.	DMAS agrees that where possible, uniformity of processes and procedures is ideal. DMAS will work with providers and MCOs to identify any possible streamlining of documentation while respecting the proprietary nature of some MCO processes.
	Any measurements of performance on the part of the insurance carriers built into the program need to be carefully constructed to insure they truly measure compliance with the contract between the state and the carriers.	Checks and balances is an important part of any program and DMAS intends to create a contract that provides flexibility to providers and MCOs while requiring accountability in order to ensure program success.
	Concerns expressed regarding the potential increased administrative burdens on home care agencies that implementation of MLTSS will cause. This concern is particularly worrisome because of the Centers for Medicare and Medicaid Services ("CMS") requirement that at least two managed care organizations ("MCO") be contracted within each region and DMAS' stated goal of contracting with at least three MCOs in each region. DMAS and/or its MCO contractors' data requests should be uniform and should utilize the same format for submission. This will reduce the administrative burden on home care agencies by permitting them to submit the same data in the same manner regardless of the MCOs they contract.	DMAS agrees that in order to address administrative burdens, where possible, uniformity of processes and procedures is ideal. DMAS will work with providers and MCOs to identify any possible streamlining of documentation while respecting the proprietary nature of some MCO processes.

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Health Plan/VIP Relationship		
Advocates	Encourages DMAS to allow VIPs, Affiliate Providers, and health systems to operate independent of MCOs (especially capitated, risk-based MCOs).	As a managed care state, it is important to maintain the continuity of coverage through the procured MLTSS and existing Medallion 3.0 managed care plans. MCOs and VIPs will work in partnership.
Health Plans	Encourages DMAS to consider allowing managed care organizations to serve as the coordinating entity for the VIPs	The DSRIP demonstration is an opportunity to support providers in a way that is not traditionally allowed through Medicaid funds. To this end, DMAS intends on maintaining the VIP model with the health systems serving as the coordinating entity. There will be contractual expectations that VIPs and MCOs work together.
	VIPs should be seen as an extension and partner with the MCOs, that together improve the current state. VIPs should not be thought of as a replacement for the MCO.	DMAS agrees that the VIPs and MCOs should have a strong partner relationship, bringing shared value to each partner and better health to the Medicaid beneficiary. DMAS has at no time considered VIPs as a vehicle to replacing MCOs.
	We do not support the formation of Virginia Integrated Partnerships as it is structured in the current draft as this seems to promote fragmentation and duplication, as opposed to reducing it.	The proposed formation of VIPs is a vehicle to bring together various providers, creating synergy between care and care coordination and infusing a comprehensive technology platform in order to share data for better continuity of health provider, community supports, and health plan information.
Payment Reform		
Health Plans	Requests flexibility in development of proposed alternate payment models and value based-purchasing	DMAS supports this idea and intends to work with all parties to create the expectations and milestones to be met, while allowing flexibility in model design.
	Suggests value-based purchasing incentives should be required but allowed to develop as the LTSS network	DMAS has full intention for the movement to value-based purchasing to be an evolution. There will be

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	migrates to managed care.	expectations and milestones to advance the system towards value based purchasing but there is not an expectation that this will be a "turn key" process.
	It is mentioned that alternative payment models will be implemented through the VIPs in tandem with the MCOs. If this is to be done with a specific population, such as MLTSS, we do not recommend prescribing specific VBP models in the first seven years of implementations, particularly those that involve the provider's capability to share risk. There may be some pockets of PCPs/other providers that are capable of and have the critical mass necessary to engage in these models, but we feel strongly against the Department dictating any one model in its contract with MCOs, as this may ultimately present unintentional consequences the member.	DMAS has explained that the movement towards value-based purchasing models is considered to be an evolution. The approach to implementing MLTSS and DSRIP in tandem is to support the provider community in order to ensure that the providers, MCOs, and the department are all ready to participate in value-based purchasing arrangements in future years. DMAS expects milestones to be met in working towards value-based purchasing arrangements which will result in the delivery of high quality care for Medicaid beneficiaries.
Providers	It will be important to develop alternative payment models that 1) encourage the willing participation of all providers needed to support the population's needs, 2) preserve existing, effective provider relationships to support patient-centered and coordinated care, 3) introduce reimbursement policies that support the integration of clinical services with community social supports, and 4) provide funding support for interdisciplinary teams that can address the needs of the targeted complex patient populations.	DMAS appreciates the thoughtful nature of this response and the suggested tenants on which to develop the initial framework around alternative or value-based payment strategies. DMAS has included these elements in the waiver application and is committed to working with all stakeholders to develop the best solution towards a system that rewards and drives further quality care for Medicaid members.
	Concerns regarding base methodology for value-based payment/alternative payment models	DMAS recognizes the differentiation among provider reimbursement and understands that value-based reimbursement strategies may vary depending upon the provider. DMAS will work to ensure that there is

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		no unnecessary harm to providers, while moving towards a more value-based and accountable system of care.
High Risk/High Utilizer		
Health Plans	Currently, MCOs employ sophisticated risk-stratification tools to identify their 'high-risk' populations, for which they subsequently allocate internal resources to better manage these individuals. How will 'super-utilizer' populations be defined and identified in this proposal?	General definitions for high-risk and high-utilizer are outlined in the proposal. DMAS has requested information from health plans regarding their ideas and existing methodologies used to identify high-risk/high-utilizer beneficiaries. DMAS will work with all appropriate stakeholders to ensure the definition meets the stated intent of the proposal, while being appropriate for the health plan and provider communities.
Providers	We encourage DMAS to promote the inclusion of maternal child health home visiting programs as affiliates / community partners in the DSRIP application. While pregnant women and young children are generally not considered to be Medicaid cost drivers, specific high risk and high utilizer subpopulations such as pregnant women with gestational diabetes, preterm / low birth weight infants and young children with special health care needs would certainly fall within this definition as expensive to serve populations.	DMAS appreciates this perspective and will consider this recommendation as it further develops the DSRIP program.
	It is suggested that the population in the waiver be expanded to include the "emerging high utilization population" to mitigate the inappropriate utilization and	DMAS agrees and has added to the application, a definition and expectation that an 'emerging high-utilization population' be included in the VIP

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	engage with the population prior to the expenditure of significant costs.	catchment. Emerging high-utilization population shall be defined as beneficiaries that have the proclivity to become high utilizers. VIPs will work in collaboration with the Managed Care Plans to develop predictive models to identify factors for high utilization and introduce preventive strategies with community partners.
Data and Technology		
Health Plans	Suggests MCOs be allowed to retain their technology platforms and proprietary processes while still facilitating simple data exchange through a central system	DMAS intends to invest in technology to support the data sharing goals and acknowledges the significant investment of both plans and providers, alike.
	Process flows and technology are equally important	DMAS agrees and works diligently to ensure that both information technology staff and general program and policy staff work in tandem to ensure the technology is driven by the business processes.
	How would this system integrate with the HIE/APCD and other tools/HIT systems that are currently in use with the health plans and hospital systems?	The waiver document states: "DSRIP will allow DMAS to work with participating VIP partners to leverage and build upon existing systems and resources and develop an optimal data system." DMAS understands the significant investments made to date and plans to leverage existing systems and resources for health plans and hospital systems as well.
Providers	DMAS encouraged to consider a successful but sizeable expectation around data integration	DMAS understands the ideal of "full data integration" is significant. The Department will work with stakeholders to identify and prioritize an

Stakeholder Group	Comment Theme	DMAS Response
		optimal data integration plan in order to be successful across providers, to include community based providers, health plans, and DMAS. DMAS responded in the waiver application with the removal of "full" therefore emphasizing the importance of data integration, without unachievable expectations.
Evaluation/Metrics		
Providers	In order to truly evaluate the effectiveness of the alignment of these strategic initiatives, we encourage DMAS to develop quality measurements of the healthcare provided at the beginning of the program	DMAS agrees that quality measurements need to be identified and monitored as soon as possible in order to gain insight into the benefit of the aligned MLTSS and DSRIP initiatives. DMAS will work consider the proposed quality measurements in determining the best metrics to monitor and report. Further, DMAS appreciates the suggested elements for inclusion into the RFP design for selecting MLTSS health plans and further DSRIP design.
	DMAS encouraged to include process measures	The Department recognizes this distinction and will incorporate such measures during the negotiation of Special Terms and Conditions between the department and CMS. The addition of metrics to this expectation has been included in the application.
Future Stakeholder Involvement		
Health Plans	Notes that a threshold issue experienced and overcome in other markets is engaging providers (acute and LTSS), consumer advocates, regulators, and other key	DMAS appreciates this perspective and agrees that it is essential that all stakeholders work together to design and implement a beneficiary centered care

Stakeholder Group	Comment Theme	DMAS Response
	stakeholders early in the process.	system that rewards improving quality, balances HCBS, and keeps the member in their setting of choice.
Providers	Requests for DMAS to engage the provider community in the further development of DSRIP related specifics	DMAS appreciates the recognition that staff has aimed to put together a thoughtful program framework to support providers, at varying levels of practice capacity, in order to create a stronger Medicaid delivery system. DMAS will incorporate and include provider representatives as more targeted program details are identified.
Suggestions/Comments Regarding Services or Provider Groups		
Advocates	Coverage should be provided for routine oral health care and follow up procedures, prescriptions, following an emergency procedure. Oral health should be included in care models and data sharing information	The Department agrees that oral health is a valuable component to overall health of Medicaid beneficiaries. DMAS also understands that there is a marked association between oral disease and systemic illness. From the onset, DMAS shared that this waiver application process would not be able to add services or benefits apart from what is currently covered under Medicaid. Oral health services will be covered only in the scope of which they are covered under the current Medicaid program. To that end, in a desire to capture and share more than claims related data, DMAS will consider the benefit and policy behind capturing and sharing oral health data information.
	Community Health Workers (CHWs) are aligned to support the outreach, education, and navigation proposals included in the waiver application.	The Department appreciates these thoughtful comments and as discussed in conversation, will look forward to working out potential details and partnership options with CHWs in their support of

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	CHWs can also help facilitate diversion from Emergency Departments and help link beneficiaries to housing and employment resources CHWs have developed workforce training criteria and would be able to modify the criteria for participation with VIPs	DSRIP efforts.
Health Plans	Encourages DMAS to consider including dental providers in the VIP partnerships, regardless of coverage as there are safety net and charity dental providers available.	DMAS appreciates this acknowledgement and agrees that oral health is a valuable component to overall health of Medicaid beneficiaries. Where geographically available, DMAS will encourage VIPs to identify and partner with willing dental providers, further supporting a fully integrated care model.
	In this structure, do MCOs have the autonomy to choose who they contract with in the VIP?	As currently proposed, MCOs would have the choice between VIPs if more than one existed in the region in which the MCO participated; however, the VIP is considered to be one entity and therefore the MCO would not be able to select individual providers to provide VIP related services to high-utilizers. Individual providers within a VIP may be chosen to participate in the MLTSS network for beneficiaries not assigned to a VIP.
	Will members be required to change their providers during the attribution process? If so, how will continuity of care be mitigated?	Details regarding the attribution of high-risk/super utilizer members have not been finalized. The Department intends on doing an initial analysis of member providers to determine if there is continuity of providers currently serving this population. DMAS will work with providers and MCOs to help identify the best method of attribution. Further, continuity of care will in no way be mitigated, rather policies

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		will be set to ensure continuity of care is in place for members at all times.
Providers	As DMAS begins to develop DSRIP related focused initiatives, we respectfully request that the services currently provided through CHIP and other validated MCH home visiting programs be considered and included.	DMAS appreciates the work already accomplished by CHIP of Virginia and their related partners and will consider this request and encourage CHIPs continued engagement in this process as it evolves.
	Appreciation that the DSRIP component of the waiver addresses this issue of behavioral health workforce capacity and recognizes the value of investing in the training of more Psych NPs, in particular.	DMAS believes fully in the integration of physical and behavioral health care and appreciates the opportunity, afforded through DSRIP to potentially invest in training more practitioners. DMAS will work with engaged partners to further develop this strategy.
	Encouraged to incorporate and leverage the work of Area Agencies on Aging across the Commonwealth	DMAS appreciates the relationship with local Area Agencies on Aging and will rely on AAAs to advise and support the Department in developing models that leverage existing work and best practices already under way throughout the Commonwealth.
General Questions/Comments		
Providers	DMAS encouraged to exercise and request maxim flexibility when considering programs for optimal transformation	DMAS agrees that there are many project opportunities that have not been described, yet could render significant transformations in the Medicaid delivery system. DMAS is open to many options, including those not yet defined, in order to strengthen Virginia's Medicaid program.

Stakeholder Group	Comment Theme	DMAS Response
	Concerning the VIP geographic regions, there is an expressed concern that there needs to be a definition around 'geographic regions.'	DMAS agrees that more clarity is valuable and has included in the application clarification of geographic regions, described as suggested: 'where there is an adequate volume of MLTSS and Medallion 3.0 enrollees who meet the criteria to support the transformation of the regional delivery system."
	Clarification is needed regarding how the VIP will interact with the nursing center residents who are Medicaid beneficiaries, the managed care entity and the providers.	DMAS acknowledges that this relationship is not yet detailed and will include nursing facilities in the creation of this model as it interfaces with nursing facility residents.